Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 22, 2014

Ms. Susan Sweetser, Administrator
Ethan Allen Residence
1200 North Avenue
Burlington, VT 05408-2777

Dear Ms. Sweetser:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 24, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0128	A. BUILDING: _____ B. WING _____	C 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 11/24/14. The following regulatory violations were identified.	R100	**V. 5.5 General Care: Regarding basic needs unmet:** The following actions were taken and implemented into resident care: Effective immediately (11/25/2014)	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interviews the home failed to assure the necessary care and services were provided to meet the identified physical care needs of 1 of 3 residents reviewed. (Resident #1). Findings include: Per record review Resident #1, who was admitted to the facility on 6/4/14 with advanced dementia had a Resident Assessment completed on 6/17/14, and updated on 10/18/14, that identified inadequate bladder control with multiple daily episodes of incontinence and the need for extensive assistance with toileting and personal hygiene. The resident's care plan directed staff to check the resident to assure s/he remained dry and provide prompt peri care when soiled. A nursing progress note, dated 11/13/14 at 9:00 PM stated; "....has a red, raw very painful area	R126	• Skin care protocol for incontinence care and skin care hygiene was developed and implemented immediately. • A Toileting and Skin care Flow sheet was developed to document toileting, hygiene, and skin condition on a daily basis. • All care giving staff attended an inservice and had 1:1 training to follow the skin care protocol for skin assessment, hygiene, toileting, and pericare practices. The inservice included assessment, documentation of skin condition, toileting, and pericare practices and use of the newly developed skin assessment and toileting flow sheet. • All residents has skin assessments conducted and documented immediately. Any resident with abnormal skin condition had immediate implementation of the skin care protocol. • All residents with abnormal skin condition due to urinary incontinence had their physicians notified to request standard medical orders for creams, ointments or	

R126, R136, + R145 POCs accepted 12/17/14 BHowe RN/PM

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R126	Continued From page 1 between [his/her] buttocks, R, L groin, peri area, vulva. Even after gently washing areas with soap and water a putrid odor remained....doctor was faxed regarding the problem." Despite these symptoms, there was no assessment of the resident's temperature or other vital signs and, although a fax was sent to the resident's physician there was no reassessment of the resident, no evidence of any response by the physician or follow up of any kind related to this clinical finding. Per review of resident care flow sheets, and despite the assessment that Resident #1 exhibited inadequate bladder control with multiple daily episodes of incontinence, there was documentation that staff assisted the resident with peri-care/incontinence care only 17 times in 14 days. A note faxed to the resident's physician, dated 11/15/14, stated that staff had checked on the resident, on that date at 12 midnight and 2:00 AM without concerns, however, when staff checked on him/her at 5:30 AM, the resident's condition had deteriorated, s/he was noted to have shallow breathing and decreased strength and was transferred to the hospital for evaluation and admission. A subsequent nursing note, dated 11/19/14 indicated that a representative of Resident #1 had informed the Director of Nursing (DON) on that date, that the resident had been admitted to the hospital with sepsis, was gravely ill, and that, upon arrival to the hospital, staff there had expressed concern regarding "...such deplorable skin care." During interview, at 11:54 AM on 11/24/14, the DON confirmed the lack of nursing reassessment and follow-up with the physician regarding care and treatment of Resident #1's skin breakdown. S/he further confirmed the lack of documentation regarding provision of peri-care/incontinence	R126	powders as appropriate. Follow through was completed for signed orders on all residents with urinary incontinence by documentation as a nursing measure in the MAR. • All residents with abnormal skin condition due to urinary incontinence will receive toileting every two hours, with hygiene and skin care according to the skin care protocol. • All residents identified with incontinence - either partial or full requiring the use of depends will had their care plan updated to document toileting, skin assessments and pericare hygiene. • Ongoing skin care assessments are being made daily on those with incontinence and weekly on those without incontinence. All assessments are documented in Toileting and Skin care flow sheet and/or in the nursing notes. • Any new identification of abnormal skin condition is being managed by following the skin care protocol. Systemic changes made to ensure deficient practices do not recur: Effective immediately (11/25/2014) • Implementation of toileting and skin care flow sheets for residents with urinary incontinence to record, manage, and track	

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R126	Continued From page 2 care.	R126	skin condition and implementation of the skin care protocol.	
R136 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interviews nursing failed to conduct ongoing reassessments following an identified change in condition for 1 of 3 residents reviewed. (Resident #1). Findings include: Per record review Resident #1, who was admitted to the facility on 6/4/14 with advanced dementia had a Resident Assessment completed on 6/17/14, and updated on 10/18/14, that identified inadequate bladder control with multiple daily episodes of incontinence and the need for extensive assistance with toileting and personal hygiene. The resident's care plan directed staff to check the resident to assure s/he remained dry and provide prompt peri care when soiled. A nursing progress note, dated 11/13/14 at 9:00 PM stated; "....has a red, raw very painful area between [his/her] buttocks, R, L groin, peri area, vulva. Even after gently washing areas with soap and water a putrid odor remained....doctor was faxed regarding the problem." Despite these symptoms there was no assessment of the	R136	• For residents without urinary incontinence implementation of weekly skin assessments while bathing will be recorded on the skin care flow sheet. • Standardized orders were developed for residents with urinary incontinence requiring the use of depends, in order to have immediate availability of powders or ointments to treat antibacterial or antifungal skin conditions related to incontinence. • Documentation of need for skin assessments every shift as a nursing measure in the MAR for every resident with abnormal skin condition (until clear); and then weekly for all residents with clear intact skin. How Practices Are Being Monitored to Prevent Recurrence: Effective immediately (11/25/2014) and ongoing • Caregiving staff are being audited randomly to determine whether they are properly implementing the skin care protocol and documentation. • Skin condition is now an outcome measure being tracked as a quality indicator on a monthly basis (per resident and overall).	

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R136	Continued From page 3 resident's temperature or other vital signs and, although a fax was sent to the resident's physician there was no reassessment of the resident, no evidence of any response by the physician or follow up of any kind related to this clinical finding. Per review of resident care flow sheets, and despite the assessment that Resident #1 exhibited inadequate bladder control with multiple daily episodes of incontinence, there was documentation that staff assisted the resident with peri-care/incontinence care only 17 times in 14 days. A note faxed to the resident's physician, dated 11/15/14, stated that staff had checked on the resident, on that date at 12 midnight and 2:00 AM without concerns, however, when staff checked on him/her at 5:30 AM , the resident's condition had deteriorated, s/he was noted to have shallow breathing and decreased strength and was transferred to the hospital for evaluation and admission. A subsequent nursing note, dated 11/19/14 indicated that a representative of Resident #1 had informed the Director of Nursing (DON) on that date, that the resident had been admitted to the hospital with sepsis, was gravely ill, and that, upon arrival to the hospital, staff there had expressed concern regarding "...such deplorable skin care." During interview, at 11:54 AM on 11/24/14, the DON confirmed the lack of nursing reassessment and follow-up with the physician regarding care and treatment of Resident #1's skin breakdown.	R136	**V. 5.7 Assessment** The following actions were taken and implemented into resident care: Effective immediately (11/25/2014) and ongoing • Any resident with abnormal skin condition that requires assessment and/or follow up is being documented in the resident's MAR (Medical Administration Record) as a nursing measure to be addressed each shift and daily until the condition is resolved. This includes nursing assessments, and items that require nursing follow through such as response from physician about medication orders. • Nursing staff attended an inservice held on 11/25 to review standards of care, expectations of skin assessment and the importance of regular, consistent follow up. • Nursing and all caregiving staff attended an inservice held on 11/25 to review the toileting and skin care protocol with expectations of assessment to skin conditions weekly on those with normal - intact skin; and daily (every shift) for those with abnormal irritated skin conditions. Systemic changes made to ensure deficient practices do not recur: Effective immediately (11/25/2014) and ongoing	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2)	R145		

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R145	Continued From page 4 Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the home failed to assure the plan of care addressed the current needs of 1 of 3 residents reviewed. (Resident #3). Findings include: Per record review Resident #3, admitted to the facility on 12/1/12, had a history of skin breakdown which was not addressed in his/her care plan. A progress note, dated 5/7/14 stated that the resident "has redness in buttocks and perineum region without excoriation..." A note dated 10/20/14 stated, "...assisted with peri care lg bright red area in between buttocks. R & L open areas on buttocks 2 cm ...", and a subsequent progress note, dated 11/19/14 identified, "red areas on buttocks R (right) 4cm and L (left) 4 cm applied PRN zinc to area on buttocks..." Despite the history of actual skin breakdown indicating an ongoing risk for future skin break down the issue was not addressed in the resident's care plan to include interventions to prevent further skin breakdown. The Director of Nursing (DON) confirmed, during interview on the afternoon of 11/24/14, the resident's care plan did not address the actual and risk for skin break down.	R145	• Standardized toileting and skin care flow sheets for daily and weekly assessments were developed. • Nursing measures for resident skin assessment are now a measure on the resident's MAR, with the frequency of each shift, daily, or weekly depending on the degree of skin condition . How Practices Are Being Monitored to Prevent Recurrence: Effective immediately (11/25/2014) and ongoing. • Nursing staff are being audited randomly to determine whether they are making assessments, following through on the skin care protocol, and documenting appropriately. • Skin condition is now an outcome measure being tracked as a quality indicator on a monthly basis (per resident and overall). **V 5.9 Plan of Care** The following actions were taken and implemented into resident care: Effective 12/15/2014 • All residents with urinary incontinence (partial or full) have care plans that are updated to include the skin care protocol: toileting, hygiene, peri-care, and use of ~~barrier creams, ointments, or powders.~~	

Systemic changes made to ensure deficient practices do not recur: Effective immediately 12/15/2014 and ongoing

- A monthly review with multidisciplinary team and nursing members will be implemented and any new problems of urinary incontinence and abnormal skin condition will be reviewed and addressed in the resident's care plan.

How Practices Are Being Monitored to Prevent Recurrence: Effective immediately (12/15/2014) and ongoing.

- Random auditing of care plans will be done to ensure that care plans are maintained up to date.
- A monthly review with multidisciplinary team and nursing members will be implemented and any new problems of urinary incontinence and abnormal skin condition will be reviewed and addressed in the resident's care plan.